

STANDARD CERTIFICATE OF DEATH

State File No. 1678

Registration District No. 25

Primary Registration District No. 1001

Registrar's No. 22

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St Joseph Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether)
In this community 13 years (years, months or days)

3. (a) PRINT FULL NAME Charles S Abbott

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Martha E Abbott 6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased Apr 1 1870 (Month) (Day) (Year)

8. AGE: Years 71 Months 9 Days 27 If less than one day hr. min.

9. Birthplace Fort Waine Ind (City, town, or county) (State or foreign country)

10. Usual occupation Painter

11. Industry or business.

MOTHER FATHER { 12. Name George Abbott
13. Birthplace Ind (City, town, or county) (State or foreign country)
14. Maiden name Louisa Weaver
15. Birthplace Ind (City, town, or county) (State or foreign country)

16. (a) Informant Miss Wameta Abbott
(b) Address Industrial City
17. (a) Burial (b) Date thereof Jan 28 1942 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Fleming & Son Inc
(b) Address St Joseph, Missouri
19. (a) Jan 29 1942 (b) H. J. Westphal (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew
(c) City or town Industrial City (If outside city or town limits, write "RURAL")
(d) Street No. RR #3 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 28
year 1942 hour 4 minute 40 P.M.

21. I hereby certify that I attended the deceased from Jan 26 1942 to Jan 28 1942
that I last saw him alive on Jan 28 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Metastatic Duration
Carcinoma of Brain
Lung

Due to Terminal Pneumonia Hypertension

Due to

Other conditions X
(Include pregnancy within 3 months of death)

Major findings:
Of operations X

Of autopsy Yes

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature Dr. W. H. St. Clair (M. D. or other) MD
Address St Joseph, Mo Date signed 1-29-42

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Jan 28 1942, Registered Apprentice No. _____
working under my personal supervision.

Signed

John P. Shirley

Licensed Embalmer No. 4050

P. O. Address

St Joseph Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1678
Registrar's No. _____

Registration District No. 85

Primary Registration District No. 1001

1. PLACE OF DEATH

- (a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)
In this community _____

3. (a) PRINT FULL NAME Charles S. Abbott

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Apr. (Month) 1 (Day) 1942 (Year)

8. AGE: Years 71 Months 9 Days 1 min. 1
(If less than one day)

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, that I last saw him _____, 19____, and that death occurred on the date and hour stated above.
Immediate cause of death _____

Carcinoma Lung
Secondary of Brain
Primary Metastatic

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(c) Manner of injury _____
23. Signature Dr. W. H. H. H. (M. D. or other) M.D.
Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

5-1678